

22.10 The unit of output for cost finding shall be the costs of routine services per patient day. The same cost finding method shall be used for all long-term care facilities. Total allowable costs shall be divided by the actual days of care to determine the cost per bed day. Total allowable costs shall be allocated based on the occupancy data reported and the following statistical bases:

22.10.1 Nursing Salaries. Services provided and hours of nursing care by licensed personnel and other nursing staff.

22.10.2 Other Nursing Costs. Nursing salaries cost allocations.

22.10.3 Plant operation and maintenance. Square feet serviced.

22.10.4 Housekeeping. Square feet serviced.

22.10.5 Laundry. Patient days, or pounds of laundry whichever is most appropriate.

22.10.6 Dietary. Number of meals served.

22.10.7 General and Administrative and Financial and Other Expenses. Total accumulated costs not including General and Administrative and Financial Expense.

## 23 ALLOWABILITY OF COST

23.1 If these principles do not set forth a determination of whether or not a cost is allowable or sufficiently define a term used reference will be made first, to the Medicare Provider Reimbursement Manual (HIM-15) guidelines followed by the Internal Revenue Service Guidelines in effect at the time of such determination if the HIM-15 is silent on the issues.

## 24 COST RELATED TO PATIENT CARE

24.1 Principle. Federal law requires that payment for long term care facility services provided under Medicaid shall be provided through the use of rates which are reasonable and adequate to meet costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. Costs incurred by efficiently and economically operated facilities include costs which are reasonable, necessary and related to patient care, subject to principles relating to specific items of revenue and cost.

24.2 Costs must be ordinary and necessary and related to patient care. They must be of the nature and magnitude that prudent and cost conscious management would pay for a specific item or service.

24.3 Costs must not be of the type conceived for the purpose of circumventing the regulations. Such costs will be disallowed under Section 26.

24.4 Costs that relate to inefficient, unnecessary or luxurious care or unnecessary or luxurious facilities or to activities not common and accepted in the nursing home field are not allowable.

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24.5 Compensation to be allowable must be reasonable and for services that are necessary and related to patient care and pertinent to the operation of the facility. The services must actually be performed and must be paid in full. The compensation must be reported to all appropriate state and federal tax authorities to the extent required by law for income tax, social security, and unemployment insurance purposes.

24.6 Costs which must be incurred to comply with changes in federal or state laws and regulations and not specified in these regulations for increased care and improved facilities which become effective subsequent to October 1, 1993 are to be considered reasonable and necessary costs. These costs will be reimbursed as a fixed cost until the Department calculates the Statewide peer group mean cost of compliance from the facility's fiscal year data following the fiscal year the cost was originally incurred. Following the second fiscal year the facility will be reimbursed the statewide average cost of compliance. The statewide average cost for this regulation/law will be built into the appropriate cost component in subsequent years.

24.7 Costs incurred for patient services that are rendered in common to Medicaid patients as well as to non-Medicaid patients, will be allowed on a pro rata basis, unless there is a specific allocation defined elsewhere in these Principles.

24.8 Lower of Cost or Charges. In no case may payment exceed the facility's customary charges to the general public for the lowest semi-private room rate in the nursing facility. These charges must be billed to private pay residents during the operating period they are incurred.

24.9 Cost to Related Organizations Principle. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable costs of the provider at the cost to the related organization. However, such costs must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere. Providers should reference Section 21 of these Principles.

## 25 UPPER PAYMENT LIMITS

25.1 Aggregate payments to nursing facilities pursuant to these rules may not exceed the limits established for such payments in 42 CFR. §447.272, using Medicare principles of reimbursement.

25.2 If the Division of Audit projects that Medicaid payments to nursing facilities in the aggregate will exceed the Medicare upper limit, the Division of Audit shall limit some or all of the payments to providers to the level that would reduce the aggregate payments to the Medicare upper limit as set forth in subsection 25.4.

25.3 In computing the projections that Medicaid payments in the aggregate are within the Medicare Upper Limit, any facility exceeding 112% of the State mean allowable routine service costs, may be notified that additional information is required to determine allowable costs under the Medicare Principles of Reimbursement including any exceptions as stated in 42 CFR 413.30(f). This information may be requested within 30 days of the effective date of these regulations, and thereafter, at the time the interim rates are set.

25.4 Facility Rate Limitations if Aggregate Limit is Exceeded. If the Department projects that the Medicaid payments to nursing homes in the aggregate exceed the Medicare upper limit, the Department shall limit payments to those facilities whose projected Medicaid payments exceed what would have been paid using Medicare Principles of Reimbursement. The Department will notify the facilities when the Department projects that the Medicaid payments to nursing homes in the aggregate exceed the Medicare upper limit and that the Department must limit payments to those facilities to the level that would reduce the aggregate payments to the Medicare upper limit.

## 26 SUBSTANCE OVER FORM

The cost effect of transactions that have the effect of circumventing these rules may be adjusted by the Department on the principle that the substance of the transaction shall prevail over the form.

## 27 RECORD KEEPING AND RETENTION OF RECORDS

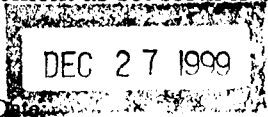
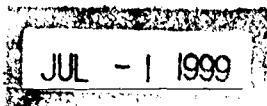
27.1 Each provider must maintain complete documentation, including accurate financial and statistical records, to substantiate the data reported on the cost report, and must, upon request, make these records available to the Department, or the U.S. Department of Health and Human Services, and the authorized representatives of either agency.

27.2 Complete documentation means clear evidence of all of the financial transactions of the provider and affiliated entities, including but not limited to census data, ledgers, books, invoices, bank statements, canceled checks, payroll records, copies of governmental filings, time records, time cards, purchase requisitions, purchase orders, inventory records, basis of apportioning costs, matters of provider ownership and organization, resident service charge schedule and amounts of income received by service, or any other record which is necessary to provide the Commissioner with the highest degree of confidence in the reliability of the claim for reimbursement. For purposes of this definition, affiliated entities shall extend to realty, management and other entities for which any reimbursement is directly or indirectly claimed whether or not they fall within the definition of related parties.

27.3 The provider shall maintain all such records for at least three years from the date of filing, or the date upon the which the fiscal and statistical records were to be filed, whichever is the later. The Division of Audit shall keep all cost reports, supporting documentation submitted by the provider, correspondence, workpapers and other analysis supporting audits for a period of three years. In the event of litigation or appeal involving rates established under these regulations, the provider and Division of Audit shall retain all records which are in any way related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.

27.4 When the Department of Human Services determines that a provider is not maintaining records as outlined above for the determination of reasonable cost under the program, the Department, upon determination of just cause, shall send a written notice to the provider that in thirty days the Department intends to reduce payments, unless otherwise specified, to a 90% level of reimbursement as set forth in Section 152 of these Principles. The

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notice shall contain an explanation of the deficiencies. Payments shall remain reduced until the Department is assured that adequate records are maintained, at which time reimbursement will be reinstated at the full rate from that time forward. If, upon appeal, the provider documents that there was not just cause for the reduction in payment, all withheld amounts will be restored to the provider.

### 30 FINANCIAL REPORTING

### 31 MASTER FILE

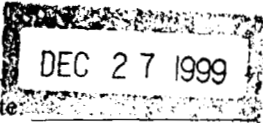
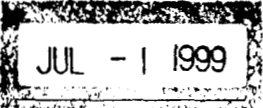
The following documents concerning the provider or, where relevant, any entity related to the Provider, will be submitted to the Department at the time that the cost report is filed. Such documents will be updated to reflect any changes on a yearly basis with the filing of a cost report. Such documents shall be used to establish a Master file for each facility in the Maine Medicaid program:

- 31.1 Copies of the articles of incorporation and bylaws, of partnership agreements of any provider or any entity related to the provider;
- 31.2 Chart of accounts and procedures manual, including procurement standards established pursuant to Section 21;
- 31.3 Plant layout if available;
- 31.4 Terms of capital stock and bond issues;
- 31.5 Copies of long-term contracts, including but not limited to leases, pension plans, profit sharing and bonus agreements;
- 31.6 Schedules for amortization of long-term debt and depreciation of plant assets;
- 31.7 Summary of accounting principles, cost allocation plans, and step-down statistics used by the provider;
- 31.8 Related party information on affiliations, and contractual arrangements;
- 31.9 Tax returns of the nursing facility; and
- 31.10 Any other documentation requested by the Department for purposes of establishing a rate or conducting an audit.

If any of the items listed in Subsections 31.1 - 31.10 are not submitted in a timely fashion the Department may impose the deficiency per diem rate described in Section 152 of these Principles.

### 32 UNIFORM COST REPORTS

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32.1 All long-term care facilities are required to submit cost reports as prescribed herein to the State of Maine Department of Human Services, Division of Audit, State House Station 11, Augusta, ME, 04333. Such cost reports shall be based on the fiscal year of the facility. If a nursing facility determines from the as filed cost report that the nursing facility owes moneys to the Department of Human Services, a check equal to 50% of the amount owed to the Department will accompany the cost report. If a check is not received with the cost report the Department may elect to offset the current payments to the facility until the entire amount is collected from the provider.

32.2 Forms. Annual report forms shall be provided or approved for use by long-term care facilities in the State of Maine by the Department of Human Services.

32.3 Each long-term care facility in Maine must submit an annual cost report within three months of the end of each fiscal year on forms prescribed by the Division of Audit. If available, the long-term care facility can submit a copy of the cost report on a computer disk. The inclusive dates of the reporting year shall be the 12 month period of each provider's fiscal year, unless advance authorization to submit a report for a lesser period has been granted by the Director of the Division of Audit. Failure to submit a cost report in the time prescribed above may result in the Department imposing the deficiency per diem rate described in Section 152.

32.4 Certification by operator. The cost report is to be certified by the owner and administrator of the facility. If the return is prepared by someone other than the facility, the preparer must also sign the report.

32.5 The original and one copy of the cost report must be submitted to the Division of Audit. All documents must bear original signatures.

32.6 The following supporting documentation is required to be submitted with the cost report:

32.61 Financial statements,

32.62 Most recently filed Medicare Cost Report (if a participant in the Medicare Program),

32.63 Reconciliation of the financial statements to the cost report.

32.7 Cents are omitted in the preparation of all schedules except when inclusion is required to properly reflect per diem costs or rates.

### 33 ADEQUACY AND TIMELINESS OF FILING

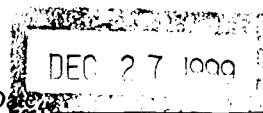
33.1 The cost report and financial statements for each facility shall be filed not later than three months after the fiscal year end of the provider. When a provider fails to file an acceptable cost report by the due date, the Department may send the provider a notice by certified mail, return receipt requested, advising the provider that all payments are suspended on receipt of the notice until an acceptable cost report is filed. Reimbursement will then be reinstated at the full rate from that time forward but, reimbursement for the suspension period shall be made at the deficiency rate of 90%.

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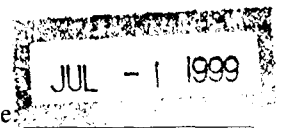
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33.2 The Division of Audit may reject any filing which does not comply with these regulations. In such case, the report shall be deemed not filed, until refiled and in compliance.

33.3 Extensions for filing of the cost report beyond the prescribed deadline must be requested as follows:

33.31 All requests for extension of time to file a cost report must be in writing, and must be received by the Division of Audit 15 days prior to the due date. The provider must clearly explain the reason for the request and specify the date on which the Division of Audit will receive the report.

33.32 The Division of Audit will not grant automatic extensions. Such extensions will be granted for good cause only, at the Director of the Division of Audits sole discretion, based on the merits of each request. A "good cause" is one that supplies a substantial basis for the delay or an intervening action beyond the provider's control. The following are not considered "good cause"; ignorance of the rule, inconvenience, or a cost report preparer engaged in other work.

#### 34 REVIEW OF COST REPORTS BY THE DIVISION OF AUDIT

##### 34.1 Uniform Desk Review

34.11 The Division of Audit shall perform a uniform desk review on each cost report submitted.

34.12 The uniform desk review is an analysis of the provider's cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded thereon, allowable costs and a summary of the results of the review. The Division of audit will schedule an on-site audit or will prepare a settlement based on the findings determined by the uniform desk review.

34.13 Uniform desk reviews shall be completed within 180 days after receipt of an acceptable cost report filing, including financial statements and other information requested from the provider except in unusual situations, including but not limited to, delays in obtaining necessary information from a provider.

34.14 Unless the Division of Audit intends to schedule an on-site audit, it shall issue a written summary report of its findings and adjustments upon completion of the uniform desk review.

##### 34.2 On-site Audit

34.21 The Division of Audit will perform on-site audits, as considered appropriate, of the provider's financial and statistical records and systems.

34.22 The Division of Audit will base its selection of a facility for an on-site audit on factors such as but not limited to: length of time since last audit, changes in facility ownership, management, or organizational structure, random sampling, evidence or official complaints of financial irregularities, questions raised in

the uniform desk review, failure to file a timely cost report without a satisfactory explanation, and prior experience.

34.23 The audit scope will be limited so as to avoid duplication of work performed by a facility's independent public accountant, provided such work is adequate to meet the Division of Audits requirements.

34.24 Upon completion of an audit, the Division of Audit shall review its draft findings and adjustments with the provider and issue a written summary of such findings.

### 35 SETTLEMENT OF COST REPORTS

35.1 Cost report determinations and decisions, otherwise final, may be reopened and corrected when the specific requirements set out below are met. The Division of Audits decision to reopen shall be based on: (1) new and material evidence submitted by the provider or discovered by the Department; or, (2) evidence of a clear and obvious material error.

35.2 Reopening means an affirmative action taken by the Division of Audit to re-examine the correctness of a determination or decision otherwise final. Such action may only be taken:

35.21 At the request of either the Department, or a provider within the applicable time period set out in paragraph 35.5; and,

35.22 When the reopening may have a material effect (more than one percent) on the provider's Medicaid rate payments.

35.3 A correction is a revision (adjustment) in the Division of Audits determination, otherwise final, which is made after a proper re-opening. A correction may be made by the Division, or the provider may be required to file an amended cost report.

35.4 A determination or decision may only be re-opened within three years from the date of notice containing the Division of Audits determination, or the date of a decision by the Commissioner or a court, except that no time limit shall apply in the event of fraud or misrepresentation.

35.5 The Division of Audit may also require or allow an amended cost report any time prior to a final audit settlement to correct material errors detected subsequent to the filing of the original cost report or to comply with applicable standards and regulations. Once a cost report is filed, however, the provider is bound by its elections. The Division of Audit shall not accept an amended cost report to avail the provider of an option it did not originally elect.

### 37 REIMBURSEMENT METHOD

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37.1 Principle. Nursing care facilities will be reimbursed for services provided to recipients under the program based on a rate which the Department establishes on a prospective basis and determines is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated facility in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards.

37.2 Nursing facilities costs will be periodically rebased by the Department of Human Services when the Commissioner of the Department of Human Services determines that the rates paid to nursing facilities are in danger of failing to meet the residents needs or are in excess of costs which must be incurred by economic and efficient nursing facilities.

#### 40 COST COMPONENTS

40.1 In the prospective case mix system of reimbursement, allowable costs are grouped into cost categories. The nature of the expenses dictate which costs are allowable under these Principles of Reimbursement. The costs shall be grouped into the following four cost categories:

- 40.11 Direct Patient Care Costs,
- 40.12 Indirect Patient Care Costs,
- 40.13 Routine Costs, and
- 40.14 Fixed Costs.

Sections 41- 49 describe the cost centers in each of these categories, the limitations and allowable costs placed on each of these cost centers.

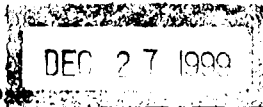
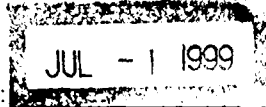
#### 41 DIRECT PATIENT CARE COST COMPONENT

The basis for reimbursement within the direct care cost component is a resident classification system that groups residents into classes according to their assessed conditions and the resources required to care for them.

41.1 Direct patient care costs include salary, wages, and benefits for:

- 41.11 registered nurses,
- 41.12 licensed practical nurses,
- 41.13 nurse aides,
- 41.14 patient activities personnel,
- 41.15 ward clerks,
- 41.16 payroll tax,
- 41.17 the following fringe benefits for the positions listed above: payroll taxes, qualified retirement plan contributions, group health, dental, and life insurance's, cafeteria plans and flexible spending plans,
- 41.18 the salary and related benefits of the position of Director of Nursing shall be excluded from the calculation of direct patient care costs and shall be included in the indirect patient care cost component.

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## 41.2 Resident assessments

The Resident Assessment Instrument (RAI) is the assessment tool approved by the Department of Human Services to provide a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. It is comprised of the Minimum Data Set currently specified for use by HCFA (hereinafter, referred to as "MDS") and the Resident Assessment Protocols (RAPs).

The MDS provides the basis for resident classification into one of 44 case mix classification groups. An additional unclassified group is assigned when assessment data are determined to be incomplete or in error. Resident assessment protocols (RAPs) are structured frameworks for organizing MDS elements and gathering additional clinically relevant information about a resident that contributes to care planning.

All residents admitted to a Nursing Facility (NF), regardless of payment source, shall be assessed using the MDS.

### 41.21 Schedule for MDS submissions

Facilities shall submit by the 25th day of the month a copy of the MDS assessments and discharge log. MDS assessments with a start date and discharges dated between and including the 16th day of the prior month and the 15th day of the current month must be submitted to the Department of Human Services or the Department's designated agent. Beginning October 1, 1994 all submissions must be made on electronic media. Failure to submit on electronic media on or after October 1, 1994 may result in reimbursement as described in Section 152.

### 41.22 Electronic Submission of the MDS Information

Effective with the implementation of version 2.0 of the MDS by the Bureau of Medical Services, all submissions must be made via electronic submission/modem. No paper copies will be accepted by the Department. Should extraordinary conditions arise whereby the nursing facility is unable to submit electronically, a request to submit MDS information via diskette shall be submitted to the Bureau of Medical Services. This request must be made a minimum of five (5) days prior to the required date of submission of the MDS assessment data.

### 41.23 Quality review of the MDS process

#### 41.23.1 Definitions

(1) "MDS assessment review" is a review conducted at nursing facilities (NFs) by the Maine Department of Human Services, for review of assessments submitted in accordance with Section 41.2 to ensure that assessments accurately reflect the resident's clinical condition.

(2) "Effective date of the Rate" is the first day of the payment quarter.

(3) "Assessment review error rate" is the percentage of unverified Case Mix Group Record in the drawn sample. Samples shall be drawn from Case Mix Group Record completed for residents who have Medicaid reimbursement.

(4) "Verified Case Mix Group Record" is a NF's completed MDS assessment form, that has been determined to accurately represent the resident's clinical condition, during the MDS assessment review process. Verification activities include reviewing resident assessment forms and supporting documentation, conducting interviews, and observing residents.

(5) "Unverified Case Mix Group Record" is one which, for reimbursement purposes, the Department has determined does not accurately represent the resident's condition, and therefore results in the resident's inaccurate classification into a case mix group that increases the case mix weight assigned to the resident.

(6) "Unverified MDS Record" is one which, for clinical purposes, does not accurately reflect the resident's condition.

#### 41.23.2 Criteria for Assessment Review

NFs may be selected for a MDS assessment review by the Department based upon but not limited to any of the following:

(1) The findings of a licensing and certification survey conducted by the Department indicate that the facility is not accurately assessing residents.

(2) An analysis of the case mix profile of NFs included but not limited to changes in the frequency distribution of their residents in the major categories or a change in the facility average case mix score.

(3) Prior resident assessment performance of the provider, including, but not limited to, ongoing problems with assessments submission deadlines, error rates, and incorrect assessment dates.

#### 41.23.3 Assessment Review Process

(1) Assessment reviews shall be conducted by staff or designated agents of the Department.

(2) Facilities selected for assessment reviews must provide reviewers with reasonable access to residents, professional and non-licensed direct care staff, the facility assessors, clinical records, and completed resident assessment instruments as well as other documentation regarding the residents' care needs and treatments.

(3) Samples shall be drawn from MDS assessments completed for residents who have Medicaid reimbursement.